Model Forms

Five Requirements for CBRF placement

Pre-Admission Assessment/Consultation
Infeasibility of In-Home Services
Consumer Preference
Quality Services & Environment
Cost-Effectiveness

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Checklist of Five Conditions for the Use of Funding in CBRFs

Name of Applicant/Participant: _____ Date: _____

Directions: Check all of the following that are true. Attach relevant documentation.

Pre-admission Assessment/Consultation

- ❑ A pre-admission assessment was performed on _____. ***OR***
  Insert date
- ❑ A pre-admission consultation (where a county waives the assessment) was performed on _____.
  Insert date
- ❑ The individual was admitted to _____ CBRF on _____.
  Insert facility name Insert date

Infeasibility of In-Home Services

- ❑ It has been documented, in accordance with HFS 73.11 that in-home services are not feasible. Documentation is attached.

Client Preference

- ❑ An exploration of applicant/participant's lifestyle preferences has been performed.
- ❑ The individual has been offered a private room.
- ❑ The individual has been informed of all residential options.
- ❑ The individual has had the opportunity to visit other facilities of their choice.

Quality Care Services in a Quality Environment

- ❑ County established quality standards have been incorporated or attached to the contract with the facility.
- ❑ County has determined that the facility can meet the unique needs of the participant considering residence.

Cost Effective

- ❑ The functional screen, COP assessment and care plan are in the applicant's file.
- ❑ CBRF services and their costs have been calculated.
- ❑ Community care cost, including nursing home and home-care costs have been calculated.
- ❑ A cost comparison shows that the facility has the capacity to effectively meet the needs of the consumer at a reasonable cost.

Determination of the Infeasibility of In-Home Services

Completion of this form satisfies the requirement under HFS 73.11

Part I: A Change has Occurred & More Services are Required

A change has occurred for the individual in at least one of the following ways (check & describe):

- ❑ Condition: _____
- ❑ Functioning: _____
- ❑ Living situation: _____
- ❑ Supports: _____
- ❑ Other: _____

Arrangements that were in place and adequate to maintain the individual's health, safety and well being before the above change occurred, are no longer sufficient to provide or ensure the provision of what the individual needs.

❑ True ❑ False

Part II: In-home Service Options Explored

The following options for supporting the individual in their own home have been explored, and have failed or been found to be unavailable or not possible. (Further space available on following page.)

Option Explored	Reason unavailable or not possible

Part III: Declaration that In-Home Care is Infeasible

In order for home-care to be determined infeasible, Part I must indicate that a change has occurred which no longer provides or ensures what the individual needs & Part II above must indicate that in-home care options have been explored and are not available or possible.

Part I & Part II above indicate that in-home care is: ❑ Infeasible ❑ Feasible

_____ _____

LTS lead agency Representative Signature Date Applicant/Guardian Signature Date

Option Explored	Reason Unavailable or Not Possible

Determination of Client Preference

Part I: Lifestyle Preferences Explored

The following preferences were explored, and the individual prefers those checked below:

❑ A private room	vs.	❑ Sharing a room
❑ Rural setting	vs.	❑ Urban setting
❑ A house	vs.	❑ An apartment
❑ Small community	vs.	❑ Large community
❑ Social atmosphere	vs.	❑ Quiet atmosphere
❑ Men or woman only	vs.	❑ Mixed gender
❑ People their age	vs.	❑ Mixed age
❑ Small setting	vs.	❑ Large setting
❑ Other: _____	vs.	❑ _____
❑ Other: _____	vs.	❑ _____
❑ Other: _____	vs.	❑ _____

Note: For those unable to express their preferences, due to cognitive limitations or an inability to communicate, an exploration has been made to determine what their most likely choices and preferences would be based on reports from family, friends, or others who have known them a long time.

Part II: Option of a Private Room

If the individual resides or intends to reside in a CBRF with more than eight beds, the individual has been offered a private bedroom at the following facility:

_____ _____
Facility Name Facility type (i.e., CBRF, RCAC, AFH)

Part III: Information and Visitation of Residential Options

The individual has been fully informed of all of the following residential options, and the advantages and disadvantages of each:

Supports in their own home/apartment:	_____ Yes	_____ No
Adult Family Home	_____ Yes	_____ No
Residential Care Apartment Complex (RCAC)	_____ Yes	_____ No
A CBRF with Independent Apartments	_____ Yes	_____ No
A small CBRF (5-8 beds)	_____ Yes	_____ No
A medium CBRF (9-20 beds)	_____ Yes	_____ No
A large CBRF (21+ beds)	_____ Yes	_____ No
A Nursing Home	_____ Yes	_____ No

Residential options presented to applicant and/or the guardian, when available, consider lifestyle preferences as determined in Part I above.

The individual has had the opportunity to visit the following facilities:

_____ Facility Name	_____ Facility type (i.e., CBRF, RCAC, AFH)
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_____ Facility Name	_____ Facility type (i.e., CBRF, RCAC, AFH)

Part IV: Declaration of Client Preference

The facility that is preferred is _____.
Facility Name

_____ Applicant /Guardian Signature Date

_____ County Representative Signature Date

Determination that CBRF is Cost-Effective

Part I: Documentation Required in Applicant's File

The following documentation is in the program applicant's file:

- ❑ Functional Screen
- ❑ Complete Community Options Program Assessment
- ❑ Care Plan

Part II: Projected Community Care Costs

The following chart lists the average total service costs of feasible community services, provided in home or in other residential settings, that meet identified needs of the individual.

Community Services (when feasible)	Average Total Service Costs
***Comparable In-home Services	***$
Comparable Adult Family Home Services	$
Comparable RCAC services	$
Comparable CBRF with Independent Apartments	$
***Comparable Nursing Home Services	***$
Other Comparable Options	$

***This calculation is required.

Part III: Cost Comparison

The total cost of _____CBRF for _____ is $_____.
Facility Name Applicant Name

Compare the costs of the chosen CBRF to the costs listed in Part II.

Part IV: Declaration of Cost Effectiveness

The cost comparison shows that the facility has the capacity to effectively meet the needs of the consumer at a reasonable cost.

True False

_____ _____
Applicant/Guardian Signature Date County Representative Date